KershawHealth Hospice

1165 Highway 1 South, Lugoff SC 29078
(803) 425-1182

Volunteer Application

Name: _____ Date: _____

Address: _____

City/Zip: _____ E-Mail: _____

County: _____

Employer: _____ Position: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Birthday: _____ Marital Status: _____

Education

Name of School	Date of Graduation	Major

What do you visualize yourself doing as a volunteer? _____

_____

Other organizations previously volunteered with (capacity, dates & locations)?

_____

_____

What did you like best about your last volunteer position? _____

_____

What did you like least about your last volunteer position? _____

_____

How did you hear about our volunteer program? ☐Newspaper ☐Friend ☐Mail ☐Family ☐Other _____

Have you ever been convicted of a misdemeanor or felony offense?
☐Yes ☐No If yes, please explain _____

What do you feel is of utmost importance when providing direct patient care to hospice patients and their caregivers/family?

_____

Have you experienced the loss of a family member/close friend? ☐Yes ☐No

Relationship _____Date of Death _____
Relationship _____Date of Death _____

Physician's Name: _____Phone: (_____)_____
Address, City, Zip: _____

List all medications: _____
_____

List any known allergies: _____

Do you have any physical limitations that would prevent you from performing direct patient care or administrative volunteer assignments? ☐Yes ☐No
If yes, please explain: _____
_____

Emergency Contact: _____Phone: (_____)_____
Relationship: _____Alternate Phone: _____

All volunteers are asked to volunteer for at least one year following the administrative or patient care training programs. Are you capable of meeting this request ☐Yes ☐No

References: (please do not list relatives)
Name: _____Years known: _____
Address, City, Zip: _____
Phone Number _____

Name: _____Years known: _____
Address, City ,Zip: _____
Phone Number_____

_____

VOLUNTEER SIGNATURE

Office Use Only
Application Received: _____